FAITH CHRISTIAN ACADEMY

Medication Release Forms

*** WE WILL NOT ADMINISTER A MEDICATION WITHOUT THIS FORM COMPLETED SPECIFIC TO THAT MEDICATION. If your child has no medication needs at this time, please keep a copy of this form at home, or *print one from our website* as soon as you know you will need it given at school (at any time during the school year unexpected illnesses or injuries could occur, making this form necessary).**

OVER-THE-COUNTER

My child, _____, requires medication during the school day. In the case of over-the-counter medication, I agree to deliver the medication to the school office in the original container. (Please consult your physician before asking us to administer aspirin to your child).

Over-the-counter medication:

I authorize the school to assist my child in taking his/her medication, and I agree that I will not hold liable the school, or any individual of official capacity who is directed by myself and/or the school administration to assist my child in taking said medication.

MEDICATION: _____

DOSAGE: _____ TIME(S) TO BE GIVEN AT SCHOOL: _____

(Specify time(s), 'as needed' is not enough information**, we must know when they last had it** and only give it when enough time has passed since the last dosage *according to the container*).

REASON(S) NEEDED:

_____

SPECIFIC INSTRUCTIONS:

_____

_____

_____

_____ _____

PARENT SIGNATURE DATE

PRESCRIPTION (whether temporary or on-going)

***PRESCRIPTION MEDICATION MUST BE DELIVERED TO THE SCHOOL BY PARENT/GAURDIAN WITH THE PHARMACY LABEL AFFIXED, INCLUDING THE CHILD'S NAME, PHYSICIAN'S NAME, DATE MEDICATION WAS PRESCRIBED, & THE NAME OF THE MEDICATION.**
THE STATEMENT BELOW, OR ANOTHER FORM USED BY YOUR PHYSICIAN WITH THIS INFORMATION, MUST ACCOMPANY THE PRESCRIBED MEDICATION.

PHYSICIAN'S STATEMENT:

The above named child, _____, requires medication during the school day as follows:

MEDICATION: _____

DOSAGE: _____ TIME TO BE GIVEN: _____

SPECIAL INSTRUCTIONS:

_____

If this is for an inhaler or epi-pen, is this considered life threatening, so they should have the device near/on them at all times? _____yes _____no &/OR Is this device considered precautionary? ____ yes ____ no

THIS ORDER IS IN EFFECT UNTIL (if there is an expiration, otherwise leave blank): _____

_____ _____ _____

PHYSICIAN'S PRINTED NAME PHYSICIAN'S SIGNATURE DATE

*PLEASE BE SURE TO COLLECT ANY UNUSED MEDICATION, OR EMPTY CONTAINERS OF MEDICATION, YOU'VE PROVIDED FOR YOUR CHILD WHEN THEY ARE DONE WITH IT. DO NOT LEAVE IT AT FCA. Thank you ☺

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